REGION X CLINIC VISIT RECORD

NAME _____ / /
(Last) (First) (MI) Client # Date of Visit

Address City State Zip Phone

(DETACH THIS PORTION AND RETAIN AT SERVICE SITE)

1. SERVICE SITE NUMBER

2. CLIENT NUMBER

3. DATE OF VISIT — MO. DAY YR. 2 0 0

4. DATE OF BIRTH — MO. DAY YR. 1 9

5. GENDER ☐ 1 - Female ☐ 2 - Male

6. ETHNICITY
☐ 6 - Hispanic or Latino ☐ 9 - Not Hispanic or Latino

6a. RACE (Mark All That Apply)
☐ 1 - White ☐ 4 - Alaska Native ☐ 8 - Native Hawaiian Pacific Islander
☐ 2 - Black/Afr. Amer. ☐ 5 - Asian
☐ 3 - American Indian ☐ 7 - Unknown/Not Reported ☐ 6 - Other

7. ADDITIONAL DEMOGRAPHIC (Check all Applicable)
☐ 4 - Person with Disabilities ☐ 6 - Homeless
☐ 5 - Limited English Proficiency

8. ZIP CODE

9. ASSIGNED SOURCE OF PAYMENT (Check One)
☐ 1 - No Charge ☐ 5 - Full Fee
☐ 2 - Title XIX (Medicaid) ☐ 6 - Partial Fee
☐ 3 - Take Charge Project ☐ 7 - Other
☐ 4 - Private Insurance ☐ 9 - Not Reported (Idaho)

18. CLIENT INSURANCE STATUS (Check One)
☐ 1 - Public Health Insurance
☐ 2 - Private Health Insurance
☐ 3 - Uninsured
☐ 4 - Unknown

10. INCOME AND FAMILY SIZE — AMOUNT
a. What is your monthly family income?
b. How many people are in your family, that is, the number supported by this income? — NUMBER

11. PREGNANCY HISTORY (Females Only) — NUMBER
a. How many times have you been pregnant?

12. PURPOSE OF VISIT
☐ 1 - Initial Medical Exam ☐ 4 - Counseling Only
☐ 2 - Annual Medical Exam ☐ 5 - Pregnancy Test Visit
☐ 3 - Other Medical

13A. **MEDICAL SERVICES** (Check all Applicable)
☐ 01 - Procedures 2 through 9 and check appropriate lab services

Exam & Lab Services
☐ 02 - Blood Pressure
☐ 03 - Height/Weight
☐ 04 - Thyroid Exam
☐ 05 - Heart/Lung Auscultation
☐ 06 - Breast Exam
☐ 07 - Abdominal Exam
☐ 08 - Extremities
☐ 09 - Bimanual/Speculum Pelvic Exam
☐ 23 - Hgb / Hct
☐ 24 - Urine dipstick / Urinalysis
☐ 25 - Pap Smear
☐ 26 - Repeat Abnormal Pap Smear
☐ 27 - Colposcopy
☐ 34 - Immunization
☐ 42 - Male Genitalia Exam
☐ 49 - Colo-Rectal Cancer Screening
☐ 36 - Other Lab or Exam
☐ 37 - No Lab or Exam

13A. **CONT. MEDICAL SERVICES** (Check all Applicable)

Contraceptive Related Services
☐ 17 - Diaphragm / Cap Fit
☐ 19 - IUD/IUS Insert
☐ 20 - Sterilization Procedure
☐ 38 - Hormone Implant In
☐ 39 - Hormone Implant Out
☐ 40 - Hormonal Injection
☐ 48 - EC-Immediate Need
☐ 46 - EC-Future Need
☐ 22 - IUD/IUS Removal

Pregnancy Related Services
☐ 21 - Post Pregnancy Exam
☐ 31 - Serum Pregnancy Test
☐ 32 - Negative Pregnancy Test
☐ 33 - Positive Pregnancy Test
☐ 35 - Infertility Screening

STD Related Services
☐ 11 - Vaginitis/STD/Eval/Dx
☐ 12 - Vaginitis/STD/Eval/RX
☐ 29 - Chlamydia Test
☐ 13 - Chlamydia Treatment
☐ 14 - Chlamydia Presumptive
☐ 15 - Wart Treatment
☐ 16 - Herpes Test
☐ 28 - Gonorrhea Test
☐ 30 - Wet Mount / Gram Stain
☐ 43 - HIV Test
☐ 47 - VDRL/RPR
☐ 50 - HPV Test

14A. COUNSELING EDUCATION PROVIDED (Check all Applicable)
☐ 01 - Contraceptive
☐ 02 - Fertility Awareness Method
☐ 03 - Sterilization
☐ 04 - Infertility
☐ 08 - Preconception
☐ 13 - Abstinence
☐ 07 - Pregnancy
☐ 09 - STD/HIV Prevention
☐ 10 - HIV Pre & Post
☐ 16 - Abnormal Pap
☐ 19 - BSE
☐ 20 - TSE
☐ 15 - Crisis
☐ 17 - Encourage Parental/ Family Involvement
☐ 18 - Relationship Safety
☐ 12 - Nutrition
☐ 05 - Tobacco
☐ 06 - Substance Abuse

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)
☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aids and lab technicians.

15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)
01 - Female Sterilization
02 - Oral Contraceptives
03 - IUD
04 - Diaphragm/Cap
11 - Hormone Implant
15 - IUS
16 - Hormonal Injection - 3 month
17 - Hormonal Patch
18 - Vaginal Ring
09 - Other Method
19 - Female Condom
06 - Male Condom
07 - Spermicide
08 - Fertility Awareness Method
13 - Abstinence
14 - Male Sterilization
20 - Withdrawal
21 - Contraceptive Sponge
10 - None

BEFORE VISIT ☐☐ AFTER VISIT ☐☐

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.
Pregnant
☐ 1 - Planned ☐ 8 - Unplanned
☐ 3 - Seeking Pregnancy
☐ 6 - Not Sexually Active
☐ 7 - Other

16. REFERRAL INFORMATION (Check all Applicable)
☐ 02 - High Risk Pregnancy
☐ 15 - Adoption
☐ 03 - Abortion
☐ 01 - Prenatal
☐ 16 - Breast Evaluation
☐ 12 - Mammography or U.S.
☐ 05 - Sterilization
☐ 06 - Infertility
☐ 07 - Fertility Awareness Method
☐ 04 - STD
☐ 17 - Colposcopy
☐ 08 - Other Medical
☐ 10 - Social Sevices
☐ 09 - Nutrition
☐ 13 - Substance Abuse
☐ 14 - Abuse/Violence
☐ 11 - None